***Ronald D. Welch, Psy.D.***

Licensed Clinical Psychologist

Transformational Marriage, PLLC

dba Transformational Marriage Counseling

Mailing Address: 6732 W. Coal Mine Avenue, #186

Littleton, CO 80123

(303) 762-6952

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Authorization Form

This form, when completed and signed by a client, authorizes Dr. Welch to release protected information from the client’s clinical record and his own clinical impressions/assessments to the individual designated AND to obtain the same information from the individual designated.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name), authorize Ronald D. Welch, Psy.D. to release to AND obtain from the designated individual all clinical information from the client’s clinical record and all clinical impressions/assessments except that which is otherwise noted here below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This information should only be released to or obtained from (name, address and phone number of the person to and from whom the information is to be shared): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I am requesting Dr. Welch release and/or obtain this information for the following reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This authorization shall remain in effect until or unless I complete a written revocation of this release of information. I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Welch’s office address. However, the revocation will not be effective to the extent that Dr. Welch has taken previous action in reliance on the authorization prior to receiving notification of revocation.

I understand that Dr. Welch generally may not make signing an authorization a condition of providing psychological services unless the psychological services are provided for the purpose of creating health information for a third party or unless the refusal to sign a release may impair offering ethical and professional clinical services.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and is no longer protected by the HIPAA Privacy Rule.

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Signature of Client/Representative Date

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Signature of Witness Date

If the authorization is signed by a personal representative of the client (e.g., Parent), a description of such representative's authority to act for the client must be provided here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_